N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42567

JAN 3 1940

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4976

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.General Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days) In this community Unk.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 1239 Lawndale (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Mary Watson 325

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Leon Watson

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Nov. (Month) 8th (Day) 1860 (Year)

8. AGE: Years 79 | Months 1 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Ill (State or foreign country)

10. Usual occupation Housewife 9

11. Industry or business ~~Home~~ 9

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) ..... (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address K.C.General Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-40 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem.

18. (a) Signature of funeral director Rose & Henderson

(b) Address 15th & Jackson

19. (a) Dec. 31, 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29th year 1939 hour 9 minute 55 A.M. M.

21. I hereby certify that I attended the deceased from Dec. 21st, 1939, to Dec. 29th, 1939; that I last saw her alive on Dec. 29th 1939, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic bronchopneumonia	
Due to Fracture of femur, accidental fall in home.	
Due to 1860	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy See above	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature P. F. De Maria M.D. (M.D. or other)

Address Supt. K.C.Gen. Hospital Date signed 1-2-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.